

New York

4

Attachment 4.19B
(8/99)

Laboratory Services

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended, or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995 and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is designated as base year in determining rates of payment, shall not exceed the statewide average of the reimbursable base year administrative and general costs of such providers of services for the twelve month period ending March 31, 1995 and 1999 rate periods, respectively, the amount of such reduction shall be applied to the agency rates of payments made during the twelve month period running from July 1 of the year prior to the respective rate period through March 31 of such respective rate period and shall be adjusted in the respective rate period on a pro-rata basis, if it is determined upon pre-audit review by June 15 of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31 of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000 shall be applied to the agency rates of payment on a pro-rata basis, if it is determined upon pre-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

TN 99-37 Approval Date APR 25 2001
Supersedes TN 97-27 Effective Date JUL 01 1999

**New York
4(a)(iii)**

**Attachment 4.19B
(8/99)**

Effective for the period August 1, 1996 through March 31, [1999] 2000, certified home health agencies (CHHAs) shall be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, [and] the 1998 target period shall mean January 1, 1998 through November 30, 1998, and the 1999 target period shall mean January 1, 1999 through November 30, 1999.) or receive a reduction in their Medicaid payments. For this purpose, regions shall consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency shall be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group shall mean all those CHHAs located within a region. Medicaid revenue percentage shall mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate shall be calculated. Prior to February 1, 1998 [and], prior to February 1, 1999, and prior to February 1, 2000, for each regional group, the Commissioner of Health shall calculate the prior year's Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage shall be calculated.

For each regional group, the 1996 target Medicaid revenue percentage shall be calculated [as the result of] by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;
and,

six-tenths of one percentage point for CHHAs located within the upstate region.

TN 99-37 Approval Date APR 25 2001
Supersedes TN 97-27 Effective Date JUL 01 1999

New York
4(a)(iv)

Attachment 4.19B
(8/99)

For 1997 and 1998, for each regional group, the target Medicaid revenue percentage for the respective year shall be calculated [the result of] by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction [percentage] percentages for 1997 and 1998, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;
and,

six-tenths of one percentage point for CHHAs located within the upstate region.

For each regional group, the 1999 target Medicaid revenue percentage shall be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

eight hundred twenty-five thousandths of one percentage point for CHHAs located within the downstate region;

forty-five hundredths of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor shall be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor shall be zero. For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

TN 99-37
Supersedes TN 97-27

Date APR 25 2001
Date JUL 01 1999

**New York
4(a)(iv)(1)**

**Attachment 4.19B
(8/99)**

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For 1997 [and], 1998, and 1999, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health shall compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

For 1997 and 1998, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

TN 99-37 Approval Date APR 25 2001
Supersedes TN 97-27 Issue Date JUL 01 1999

New York
4(a)(iv)(2)

Attachment 4.19B
(8/99)

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there shall be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region:

five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region:

For each regional group reduction, if the 1999 reduction factor is zero, there shall be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount. This amount shall be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped by the State by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997 [and], 1998, and 1999, for each regional group, the state share reduction amount for the respective year shall be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount shall be called the provider specific state share reduction amount for the applicable year.

TN 99-37 Approval Date APR 25 2001
New Effective DATE JUL 01 1999 TOTAL P.02

**New York
4(a)(v)**

**Attachment 4.19B
(8/99)**

The provider specific state share reduction amount for 1997 [and], 1998, and 1999, respectively, shall be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs shall submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health shall calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated shall be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference shall be refunded to the CHHA by the state no later than July 15, 1997. CHHAs shall submit data for the period August 1, 1996 through March 31, 1997 to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA shall be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health shall reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

TN 99-37 Approval Date APR 25 2001
Supersedes TN 97-27 Effective Date JUL 01 1999

**New York
7(a)**

**Attachment 4.19B
(8/99)**

Section 86-2.9, Adult Day Health Care in Residential Health Care Facilities, is hereby amended to read as follows:

Section 86-2.9 Adult Day Health Care in Residential Health Care Facilities: (a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(c) Allowable costs shall include, but not be limited to the following:

- (1) applicable salary and non-salary operating costs;
- (2) costs of transportation; and,
- (3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 through March 31, 1999, and from July 1, 1999 through March 31, 2000, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990 with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

TN **99-37** Approval Date APR 25 2001
Supersedes TN **97-27** Effective Date JUL 01 1999

New York
(14)

Attachment 4.10B
(8/99)

Clinic Services for Federally Qualified Native American Health Centers not subject to licensure under Article 28 of the State Public Health Law

Reimbursement for federally qualified health centers located on Native American reservations and operated by Native American tribes or tribal organizations pursuant to applicable Federal Law and for which State licensure is not required will be established consistent with the methodology applicable to freestanding diagnostic and treatment centers, including federally qualified health centers which are licensed under Article 28 of the State Public Health Law. The reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Prospective all inclusive rates of payment will be calculated by the Department of Health, based on the lower of allowable average operating cost per visit or the group ceiling trended to the current year as permitted by law, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, [1999] 2000. The facilities will be compared with other facilities offering similar types of services. The rates will include a capital component which is not subject to ceiling limitations. Rates are subject to approval of the Division of the Budget. The facilities will be required to forward to the Department of Health on an annual basis any necessary financial and statistical information.

The provisions of this section pertaining to reimbursable base year administrative and general costs of a provider of services shall be deemed to be in full force and effect through March 31, 1999[.], and from July 1, 1999 through March 31, 2000.

TN 99-37 Effective Date APR 25 1999
Supersedes TN 97-27 Effective Date JUL 01 1999